

# HEALTH CENTER INTERNAL CONTROL POLICIES AND PROCEDURES

The following accounting policies and procedures are an excerpt from the National Association of Community Health Centers Accounting Policy, Procedures, and Operations Manual for Health Center Chief Financial Officers. This manual also contains other accounting policies and procedures not described below that are beneficial for a Community Health Centers accounting department. If you would like to obtain a copy of the manual, please contact Mike Holton at the National Association of Community Health Centers or order the manual via the NACHC website at [www.nachc.com/publications](http://www.nachc.com/publications).

## Cash Disbursements

### Introduction

1. All disbursements should be made out of one general operating account except for payroll checks that are disbursed out of the payroll account.
2. Petty cash expended should be reimbursed from the regular operating account once a month or whenever the balance falls below a certain amount specified by management. The expenses are charged at the time of reimbursement.

### Disbursement Policies

1. All checks drawn by the health center must be signed by the Chief Executive Officer. If the amount of the check is in excess of *[specify limit]*, then another authorized signor of the health center or a member of the Board of Directors with check signing authority must also sign the check.
2. Expenditures over *[specify limit]* must be pre-approved by a vote of the Board of Directors before any further action can take place.

### Disbursement Procedures – Non Payroll

1. A multipart voucher is prepared for disbursements paid from the general operating account. The top copy is used as the check to send to vendors. The other copy is used to provide the health center with adequate documentation for the expenditures. The detailed procedures related to the preparation, distribution, and retention of the disbursement vouchers are prescribed in the accounts payable section.
2. Bank account reconciliation's must be completed each month to ensure that all cash transactions are properly recorded, and that there are no unusual endorsements. Each bank account is reconciled to the appropriate cash balance in the health center's general ledger. The reconciliation is performed by an employee who does not have responsibilities for the cash disbursement or receipts cycle.

### Petty Cash – Policies-General

1. The petty cash fund is used for a maximum amount of fund expenditures under *[specify limit]* and receipts must be submitted to substantiate disbursements.
2. The fund must be maintained by *[specify title of person]* who does not have access to accounting records.

### Petty Cash – Procedures-General

1. The fund's balance should be established so that it requires only one reimbursement each month. The fund is reimbursed at the end of the month or whenever the fund's balance falls below an amount determined by the management.
2. Reimbursement is paid from the general operating account upon submission of an approved requisition. The reimbursement check is drawn to the order of the fund custodian. Expenses paid out of petty cash funds are charged at the time of reimbursement.

### Procedures for Disbursement of Petty Cash Funds

1. A petty cash disbursement form is prepared for each disbursement.
2. The forms are available from the petty cash custodian.
3. All petty cash disbursement vouchers must be approved by the finance management team in advance of incurring the expense. Only the *[indicate persons title]* can approve any deviation from this requirement.
4. Individuals requisitioning funds for the purchase of miscellaneous supplies or other transactions where it is practical to obtain a receipt should make the purchase from personal funds when possible. The individual is then reimbursed from petty cash upon the presentation of an approved petty cash disbursement voucher and a receipted bill. For these transactions, an approval is obtained prior to incurring the expense and final approval is noted by the authorizing party after examining the receipted bill.
5. Petty cash advance disbursements for local travel and other expenditures where it is impractical to obtain a receipted bill or when the purchaser cannot advance the funds must be returned and the voucher adjusted and initialed by both the recipient and the fund custodian.

### Petty Cash Accounting Procedures

1. The petty cash fund custodian enters individual receipts and disbursement transactions in a petty cash ledger.
2. To replenish the petty cash fund, the custodian lists individual receipts and summarizes disbursements by account number on the petty cash reimbursement request form.

### Petty Cash Reimbursement Procedures

1. Requests for reimbursement are forwarded, together with the approved disbursement vouchers, to the accounting department.
2. The accounting department reviews the reimbursement request. If the disbursements appear to be bona fide expenses and properly approved, a regular disbursement voucher is prepared.
3. The reimbursement voucher is prepared and the petty cash vouchers are cancelled at the time of reimbursement.
4. The petty cash disbursements are accrued in the Accounts payable register. The expenses are charged to the appropriate expense accounts.
5. The reimbursement check is drawn to the order of the fund custodian.

## Cash Receipts Procedures

### Introduction

The health center receives various types of cash receipts on a daily basis. These include cash received via mail such as contract revenue reimbursement, contributions, payment on patient accounts, electronic wire transfers such as Medicaid receipts and grant drawdowns, cash from patients, and other miscellaneous items. The objectives of the cash receipts procedures include:

1. Segregation of duties to assure that receipts are adequately safeguarded and properly deposited.
2. Establishment of controls to insure that all receipts are properly recorded in the accounting records.
3. Identification of receipts in sufficient detail to facilitate preparation of the monthly financial reports.

### Receipt Procedures – Mail

1. The mail is opened by the receptionist who will then segregate checks from other material, and will then forward the other material for distribution to the appropriate individual.
2. The receptionist restrictively endorses each check and prepares a two-part daily cash receipts log. A photocopy is made of the checks received and are attached to the copy of the daily mail log and retained in a binder located in administration.
3. All checks and related documents are forwarded to the Accountant for processing and deposit.
4. The copy of the mail log is forwarded to the individual who has the duty to review the daily deposit before being deposited in the bank.
5. The Accountant then enters the cash received directly into the cash receipts subsidiary ledger that is either kept manually or using the computerized accounting software. Each check is posted against the individual accounts receivable account on a daily basis. During this process, all checks received are compared to billings and vouchers and any discrepancies between the payments and the billings are brought to the person who reviews the discrepancies.
6. For patient payments received in the mail, all checks are photocopied. All payments by individual patients are posted against the self-pay receivable and any insurance payment is posted against that particular insurance carriers account. Copies of the checks received for patient services are forwarded to the billing department for posting in the billing subsidiary system.
7. After all checks are posted, the accountant prepares the deposit in duplicate. All checks are listed individually on the deposit slip with sufficient identifying information.
8. The Accountant submits the deposit slip to the Accounting Manager for review that compares the receptionists mail log to the deposit slip for accuracy. Any discrepancies are immediately resolved and the deposit is taken to the bank.

### Front-Desk Deposits-Procedures

1. At the start of the day, a cashier is given a cash box from the safe that includes the approved starting cash amount [*enter the approved balance*].

2. The cashier and his/her supervisor then jointly confirm the starting balance in the cash drawer before the drawer is used. If the cash agrees, the cashier will then open the workstation for patients.
3. At the conclusion of each patient's visit, the cashier enters the procedure codes from the encounter form into the computerized system. The computerized system will then calculate, based on the charge schedule the appropriate charge and any discounts/allowances that should be applied against patient's balance for the day.
4. The cashier then collects the cash from the patient and posts the payment on the computerized system. If a check is received, the cashier will restrictively endorse the check. The cashier then returns a payment receipt generated by the computerized system directly to the patient regardless of the payment methodology.
5. At the conclusion of the day, the front desk personnel reconcile the cash and checks received from patients to the computerized system using the *[list reports used by personnel]*. Any discrepancies are immediately resolved.
6. After the reconciliation process is complete, the cash is secured for the night in the sites safe.
7. The next morning, the supervisors hand deliver the cash and the reconciliation sheets to the *[name of appropriate title]*. The *[employee title]* then prepares the bank deposit ticket for each site and forwards the package to the *[person in finance department]* for approval and deposit in the bank.
8. The *[accountant]* will reconcile the deposit to the daily cash sheets that were produced by the computerized system. If all the items agree, the total amount of cash, by payor source is recorded on a cash receipts log and the deposit is made.
9. At the end of the month or when deemed appropriate by the CFO, the total cash received by payor source (as listed on the cash receipts log) should be recorded in one journal entry to the appropriate patient receivable balance in the general ledger.

#### Other Sites-Procedures

If the health center has other sites that receive cash on a daily basis, these sites should all follow the same cash receipt procedures with the exception of the following:

1. If the other sites receive very little cash received during a day, the cash should be combined at the close of business and kept in a locked safe. The management should determine how often the cash is aggregated and deposited into the bank.
2. The other sites all deposit their cash on a daily basis and forward to the finance department the duplicate of the bank deposit for posting to the general ledger.

***NOTE: The procedures listed above are dependent on the size and the complexity of the entities other sites. They should be modified as needed.***

## **Requisitioning, Purchasing, and Receiving Procedures**

### Introduction

The procedures described in this section enable the health center to acquire equipment, supplies, and services while practicing good internal control procedures and follow all federal A-122 and A-110 guidelines.

### Policies

1. All health center employees must sign a conflict of interest statement that lists all businesses owned by them. This conflict of interest statement states that no purchasing of goods can be made from businesses owned by employees of the health center.
2. Per OMB Circular A-110, all purchases over \$25,000 with Federal Funds must be sent out to bid and approved by the Board of Directors.

### **Procedures:**

#### Requisitioning Procedures

The health center should establish procedures for requisitioning equipment, supplies, and services. These procedures should stipulate which employees are authorized to requisition and a dollar amount over which a purchase requisition will be used.

#### Purchasing Procedures

1. All purchase orders are to be completed by the employee who desires the goods or service and then the purchase order must be approved by the department head. If the department head is the employee requesting the goods or service, then the Executive Director or the Executive Director's designee must approve the purchase order.
2. After the purchase order is completed and approved, the purchase order is then sent to the purchasing supervisor to requisition the goods or service.
3. If the purchase order is for any goods or service that will be paid for directly from federal dollars (i.e. Community Health Center Section 330 Program) then the purchasing must follow Office of Management and Budget Circular A-110 guidelines.

#### Competitive Bid Procedures

If goods or services are to be purchased by federal dollars then at least three competitive bids must be obtained for all goods and services over \$25,000. Also, at the discretion of the Finance Director or Executive Director, competitive bids may be obtained for other goods and services as they deem appropriate. Competitive bids should be in writing and contain all payment order specifications.

After the bids are received, the designated personnel requesting the bids will recommend to the Executive Director or the Executive Directors designee as to which bid should be excepted. Since all purchases requiring a competitive bid must be approved by the Board of Directors, then the Executive Director will present the health center's decision to the Finance Committee for recommendation to the Board of Directors for approval.

### Blanket Purchase Orders

Blanket purchase orders are timesaving devices to be employed when numerous orders for a specific product, group of products, or services are needed over a length of time from the same vendor.

The purchasing department maintains a log of the blanket purchase orders. These orders should be completed with the appropriate goods to be ordered and a copy of the blanket order is retained for verification of goods when received and a copy is placed in the vendor files.

### Preparation of Purchase Order Form

1. The purchase order form is [*describe the form, i.e. two part form, etc.*]. The following information is recorded on the form:
  - a) The date the order was written
  - b) Vendor and vendor's address
  - c) Description of items ordered
  - d) Quantity, unit price, and total price for each item
  - e) Purchasing terms
  - f) Special delivery instructions
2. The purchasing department prepares and forwards, after obtaining any required competitive bids, the completed purchase order to the finance department for approval.
3. The accounts payable clerk submits the completed purchase order and quotation bid summary if necessary, to the fiscal director.
4. The fiscal director then approves and signs the purchase order, if satisfactory, and sends the package back to the accounts payable clerk for mailing and distribution. The fiscal director's signature indicates that based upon his/her experience and the documentation examined, the vendor is suitable, the price is reasonable and in accordance with prevailing market conditions, and that the documentation appears to have been prepared following established procedures.
5. The accounts payable clerk then mails the vendor copy and distributes the rest of the package as follows:
  - a) Part two is filed in numeric order in separate files. Two files are maintained: one for open orders and one for filled orders.
  - b) Part three to the receiving department. Receiving maintains this copy in numerical order for comparison to the shipment.

### Receiving Procedures

1. Goods are received at the reception desk. The receptionist will then forward all goods received to receiving department. The receiving department will then open the goods to verify the order is complete.
2. If the shipment is complete, copy of the purchase order is signed and forwarded to the accounts payable clerk. If only a partial order is received, the items received are circled on the copy of the purchase order. The purchase order is then photocopied, signed, and then forwarded to the accounts payable clerk and the original is returned to the purchase order numerical file. If an order is incomplete due to items being on back order, payment is withheld until the order is complete. If the item is deleted by the vendor, then the purchase order is reviewed and amended and paid for items received.



## **Accounts Payable Procedures**

### Introduction

The health center should maintain its accounting records on an accrual basis of accounting. This method of accounting and financial reporting relies heavily on efficient accounts payable procedures.

A policy should be established whereby the fiscal department maintains copies of purchase orders and receiving reports. These documents are employed to establish the propriety of payments on vendor's invoices. Upon the receipt of the invoice, the invoice is compared with the supportive documentation. Accounting prepares the payment voucher and records an entry in the Accounts payable register generally debiting an asset or expense account and crediting accounts payable.

### Policies

1. A voucher check should not be prepared for an open invoice until the invoice presented for payment has been matched to the receiving report, purchase order and the proper approvals have been indicated on the receiving report and purchase order.
2. All invoices received for the current month should be entered into the accounts payable system before the end of the month. Otherwise a journal entry is required to accrue for the invoices received but not entered into the general ledger system.

### **Procedures:**

#### Maintenance of Support Documentation

1. Upon receipt of the vendor's invoice, the documents that were retained in the open purchase order file are matched with the invoice and segregated, according to payment date, for further processing.

#### Voucher Preparation

1. The invoice received is compared to the receiving report and payment is made only on items received. Approval must appear on the receiving report by the receiving clerk attesting that the goods meet specification.
2. If the purchase was made based on a blanket purchase order, the blanket purchase order is reviewed for completeness. Blanket purchase orders are considered payable when the invoice is approved by the appropriate personnel.
3. If the invoice is properly supported by the receiving report, purchase order, and the arithmetic accuracy has been reviewed, the finance department prepares a voucher check and initials the check to indicate that the above steps were satisfactorily performed and the invoice is acceptable for payment.

#### Procedures When a Purchase Order is Not Required

1. Purchase orders are not required for personnel service expenditures, consultant and service fees, travel advances, rent, certain other expenditures, petty cash, etc.
2. Disbursements for payroll is supported by the payroll register.

3. Copies of contracts written for rent, consultants, and other services should be filed in the finance department. Such documents should be referenced in support of vendor payments. Invoices for consultants and other services should be approved by the appropriate personnel.
4. Travel expenses should be supported by receipts.
5. Petty cash is reimbursed upon submission of an approved reimbursement voucher.

#### Preparation of the Checks

1. The check is a [*describe form, i.e. multi-part*] form containing the check and such additional accounting information as purchase order number, description of expense, purchase price, discount, account charged, and space for the appropriate authorization.
2. The checks should be prepared for each pay period for invoices awaiting payment.
3. The appropriate person in the finance department reviews the completed check and all supporting documentation. If everything is in order, that person forwards the package to the [*individual who is designated as the signor*] who will then sign the check and forward the second copy and all supporting documentation back to the fiscal department.

#### Payment Procedures

1. Part One of the check is mailed directly to the vendor by the [*name of individual outside of the payment cycle*]. The supporting documentation is cancelled by stamping "paid" with the date on each document.
2. The accounting department then files the requisition copy, the receiving report, purchase order copy # 2, the vendor's invoice and the check copy by vendor.

## **Payroll Procedures**

### Introduction

The health center has established a policy for the preparation of payroll. The payroll should be based upon time cards maintained for each employee and advises to report deductions for unauthorized absences, new additions to the staff, and salary changes.

The time cards are generated [*enter frequency*] from the [*location of time cards, i.e. automatic payroll swipe machine*]. Each employee is required to [*list requirements, i.e. swipe their employee card each morning and afternoon*].

A log of employee's vacation days, sick days, etc. is also maintained and the time cards are adjusted appropriately for each of these types of days taken.

### Policy

The health center should prepare the payroll checks from time cards approved by the department supervisors. No payroll checks should be generated from unapproved time cards.

### **Procedures:**

#### Payroll Reports Maintained

The following reports are generated [*list by whom, i.e. the contracted payroll company*]:

1. Payroll register that identifies gross pay, less deductions and net pay by employee.
2. Employees earnings record which identifies cumulative gross pay and cumulative deductions and net pay for individual employees.
3. Available vacation balances with corresponding dollars
4. Quarterly IRS Form 941.

#### Recording Entries to Books of Accounts

At month-end, the payroll costs are accumulated by cost center and posted to the general ledger. Fringe benefits are recorded each payroll period and are apportioned to cost centers in relation to the salary expense for the period. The finance department records the current period payroll to the preceding periods payroll. Any changes must be properly supported by approved time cards or other advises.

#### Time and Effort Reports

Time and effort reports are required to be completed each pay period based on actual time spent on each program by each employee. The employee must indicate the percentage of time he/she spent on each program. The time and effort reports are then signed by each employee and their supervisor and then retained along with the time cards for each payroll period.

## Accounting for Fixed Assets

### Introduction

Fixed assets accounting procedures are applicable to capital expenditures and certain donated assets. The health center has established [*enter the dollar amount*] for capitalizing expenditures that include the purchase of buildings and equipment and leasehold improvement. The procedures describe in this section prescribes the required property records and the basis for the calculation of depreciation.

### Policies:

1. For accounting purposes, capital expenditures should be capitalized. This capitalization policy guideline is applied to an individual item over [*specify limit*]. Donated assets are treated as fixed assets when their fair market value exceeds the capitalization guideline. Donated assets are recorded at the approximate fair market value at the time of donation. Used equipment is capitalized using the same general guidelines as new equipment except that the useful life is shorter. To determine the estimated life, consider the condition and age of the asset. Used equipment is recorded at cost.
2. For any asset with a net book value of over \$5,000 and purchased with Federal Funds, the health center must obtain approval from the Funding source before disposing of the asset.
3. See Circular A-110, for additional information about property standards on fixed assets purchased with Federal dollars.

### **Procedures:**

#### Asset Classes

To provide the desired level of management control and winning clerical effort, fixed assets should be classified into the following categories defined below:

1. Land – Land has no value threshold. As long as the Center owns a parcel of land, the land is valued at the cost to the Center. If the land was donated to the Center, then the Center will record the land at the estimated fair market value of the land. Land is never depreciated.
2. Building – The health center must own the building in order to categorize the asset line item as building. All costs associated with the building, or improving the life of the building may be capitalized. Buildings are depreciated over 40 years or the useful life of the building at time of acquisition, whichever is less.
3. Leasehold improvements – Included as leasehold improvements are expenditures in excess of the capitalization policy amount to improve or otherwise extend the usefulness of leased property. These expenditures are amortized over the useful life of the improvement or the term of the lease, whichever is shorter. Repairs and expenditures, which do not improve the structure, do not qualify as leasehold improvement and are expensed in the period incurred.

4. Furniture and Equipment – Furniture and equipment includes items such as basic office furniture, computers, computer hardware (server, etc.), copiers, telephone equipment, etc. Depreciation is based upon the useful life of the specific item that was capitalized.

#### Maintenance of Property Records

The health center maintains property records to safeguard assets and provide a basis for the calculation of depreciation. Thus the health center maintains a ledger which lists all the property on the health center's balance sheet by date purchased, description of asset, useful life, cost of asset. Further, the asset records show the current year depreciation charge and total accumulated depreciation as well as net book value of the asset. As further control, all furniture and equipment are tagged with a serial number and the serial number is noted on the fixed asset ledger as well.

If the health center receives funding from an outside source (city, state, or federal government) to purchase equipment, the health center should indicate on the asset ledger which items were bought with these funds. It could be possible, depending on the source of funds, that the equipment has reversionary rights. This means that the asset may revert to the funding agency if the health center ceases the line of business that the asset was purchased for.

In addition, the health center should conduct and document a physical inventory on all fixed assets.

#### Disposal of Fixed Assets

Occasionally, an asset is sold or otherwise disposed of. Retirements are credited at cost value (cost less accumulated depreciation) based upon an advice prepared by the accountant and approved by the finance management team. The gain or loss is calculated by deducting the book value from the proceeds received, if any. Any such gain or loss is treated as miscellaneous revenues or expenses.

If the asset disposed of was purchased using federal funds from direct programs of the DHHS, approval must be obtained from the DHHS for all asset dispositions over \$ 5,000. If the asset disposed was purchased with a localities funds, approval may have to be obtained from the funding agency.

#### Calculation of Depreciation

***[The health center should establish a policy for calculating depreciation. Usually, depreciation is calculated on a straight-line basis over the estimated useful life of the asset. Unless there has been a material acquisition of property and equipment during the year, depreciation equals ½ the annual amount will be taken in the year of acquisition.]***

## **Patient Revenue and Receivable Monthly Process**

### Introduction

The health centers main revenue source is patient services. As such, policies and procedures for accounting for patient service revenue must be established for the center. At the minimum, the following procedures should be included in the policies and procedures manual:

- How cash is posted to the patient billing system
- When the posting is made to the general ledger
- Who makes all of the postings (both to the billing and accounting system)
- How the accounts are increased and decreased

In addition, the following is suggested:

### Definitions

**Charge Structure** – The amount charged to patients for services provided. The charge structure is updated each year and approximates the center's cost of providing the services.

**Current Procedural Terminology (CPT)** – The codes assigned by the American Medical Association for each type of procedure performed during a patients visit.

**Other Third Party Insurance** – All insurance carriers not including Medicaid, Medicare, and private pay patients.

**Co-Payment** – The amount required by a third party (including Medicare) that a patient must pay as part of the visit to the health center.

**All-Inclusive Rate** – The rate assigned by Medicare and Medicaid to cover all services performed during an office visit.

**Sliding Fee Program** – All patients that do not qualify for Medicaid may qualify for the Sliding Fee Program as outlined by the U.S. Department of Health and Human Services. The program allows a patient to receive a discount for services based on their family size and annual income compared to the Federal Poverty Guidelines.

### Description of payors

**Medicaid** – All Medicaid patients seen at the health center generates one patient visit that is billable to the state that provides Medicaid services at a specified rate. The rate is categorized as an all-inclusive rate meaning that the health center should be reimbursed a set rate regardless of the number of services performed by the provider during the office visit.

**Medicare** – Medicare, like Medicaid also pays the health center an all-inclusive rate for the services provided. However, unlike Medicaid, Medicare requires the health center to receive a co-payment of 20% of the charge of services performed. Thus, the agreed upon

rate of the FQHC Medicare cost report is reduced by 20% for the co-payment. It should be noted that certain services are non-reimbursable by Medicare. These include some ambulatory services, dental, in-patient procedures, etc.

**Third Party Insurance** – The health center contracts with various insurance carriers to provide services to their enrolled patients. The reimbursements for these services are based on a pre-determined fee schedule using Current Procedure Terminology codes (CPT). Each year, the health center re-negotiates the various contracts and receives a new fee schedule that the health center will use to charge the insurance carriers. If the contract requires the patient to pay a deductible or co-payment, then that portion of the cost is reimbursed by the patient.

**Managed Care Plans** – The health center can elect to contract with certain managed care plans. The managed care plans will reimburse in one of three methods. The plan may reimburse based on a per member per month (PMPM) fee. This results in the health center receiving a pre-determined amount of money each month to provide all services for the patient for the month. If the patient never utilizes the health center's services, the health center will receive the PMPM amount anyway. The second method is similar to the way third party insurance reimburses. The managed care plan will reimburse the health center based on a fee-for-service basis with possible patient co-payments or deductibles. The third method is a hybrid of the first and the second. The health center will receive a PMPM for all primary care services and receive fee-for-service reimbursement for specialty services.

**100% Self Pay** – These patients do not have any health insurance and do not qualify for either Medicaid or Medicare coverage. The patient also does not qualify for the sliding fee discount, therefore the patient is responsible for the full cost of the services and payment is required at the time of service. The reimbursement for the services is based on the health center's pre-determined charge structure.

**Self Pay Sliding Fee**– These patients also do not qualify for Medicaid coverage. However, these patients do qualify for the sliding fee program. The patients payment for the services rendered is solely based on the charges for the day less the discount given to the patient for the applicable sliding fee.

**Policy:**

1. A sliding fee discount schedule based on the Federal poverty guidelines is updated annually
2. Cost changes by procedure based on the health center's cost for providing services (using Relative Value Units – RVUs) is updated annually
3. All accounts over [insert number of days] are to be written off as doubtful accounts

## **Procedures:**

### *Determination of Charges*

The health center has established a policy on how often it books charges for each respective payor. The charges are based on the health center's current charge structure regardless of payor. For example, if a patient is seen at the Center and the provider codes the encounter form as a moderate office visit (CPT Code 99213), the Center charges an amount as per its charge structure. This charge should be booked for all payor classes regardless of how the health center is reimbursed (all inclusive rate vs. fee-for-service). Some health centers are required to charge each patient the same gross amount or else the health center could be in violation of State or Federal laws.

### *Determination of Contractual Allowance or Sliding Fee Discount*

If the health center's charge structure is based on the cost of providing services, the amount booked as the charge most often will exceed the agreed upon reimbursement rate, however, in some instances the charge may be lower. In these cases, the health center must book a contractual allowance. A contractual allowance is the difference between the charge for the service and the agreed upon rate for all payors except self pay patients. The contractual allowance is automatically generated by the billing system at the time the charges are entered into the system.

A sliding fee discount is similar to the contractual allowance in that it represents the difference between the health center's charge and the amount received. However, this category is solely for those patients who qualify for the sliding fee program under the Federal grant. The health center should verify whether or not the health center is required re-enroll each patient who is eligible for the sliding fee discounts. Each health center can have many sliding fee categories. A patient's category is determined based on the size of their family and their yearly income. As long as the patients income is below a certain percentage, specified by the Federal poverty guideline, the patient will qualify for the program. Once the determination of sliding fee category is made, the level should be entered into the computerized system. At the conclusion of a patients visit, the computerized system should apply the discount to the days charges and will then leave a balance for collection by the health enter.

### Reports Generated from the Patient Information System [name of system]

[Since each computerized system is different, procedures on how to generate reports will vary from one health center to the next.] Some reports may include:

Charges

Visits

Cash receipts Log and Cash Collections

Statistical (i.e. productivity)

### *Fiscal Departments Responsibility*

[The health center should have a policy where the fiscal department is ultimately responsible for the input of all patient revenue/receivable entries into the general ledger. Please see the section titled standard journal entries, for how to record the entries.]

## **Travel Policies and Procedures**

### Introduction

The purpose of the travel policies and procedures is to reimburse employees for funds paid in the course of performing the pre-approved activities of the health center.

### Policies

It is the policy of the health center to provide reimbursement for pre-approved travel related expenses, including transportation, hotels, and food. These expenses must be related to activities of the health center, and must be pre-approved by the appropriate level of management.

### **Procedures:**

1. All reimbursement for travel related expenses requires documentation of the expenditure through third party receipts or other verifiable documentation.
2. For local travel related to patient activities, the health center will reimburse through petty cash in accordance with applicable petty cash policies and procedures. This includes reimbursement for use of taxi and public transportation, and, when pre-approved, use of an employee's personal automobile. Reimbursements of automobile expense for use of an employee's personal automobile are limited to the mileage incurred times the federally approved mileage rate (for the year 2002, 36.5¢ per mile).
3. For out of area travel, the health center will reimburse all pre-approved travel related costs of hotel accommodations, transportation to and from the destination, including airline, train or bus tickets, taxicab fares, etc. A per diem amount of *[insert amount]* per day for food will be granted.
4. Out of area travel requires completion of a Travel Reimbursement Request form. The form must be fully and accurately completed, and submitted to the *[specify title of person]*. (All costs regardless of who paid them are to be included on this form. All receipts must be attached). We suggest the following items be included on the travel reimbursement request form:

1. Employee's name
2. Date of the submission
3. Destination
4. Purpose of the travel
5. Date of departure and the date of return, including days of the week
6. Transportation modes and costs
7. Lodging
8. Per Diem: Write the # of days and multiply by the *[insert amount]* per diem amount, and write the amount as indicated
9. Other: Write all other expenses incurred and purpose
10. Total amount to be reimbursed
11. The employee to be reimbursed must sign & date the form as indicated
12. The employee's supervisor must sign & date the form as indicated
13. Submit the form to *[specify title of person]* for obtaining the final authorizations